*Commonwealth of Virginia, Commonwealth of Opportunity*

**TO:** Virginia Health Reform Initiative Advisory Council and Task Force Members

**FROM:** Cindi B. Jones, Director
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**DATE:** **August 12, 2011 (Written comments on this Memorandum due August 26, 2011)**

**SUBJECT:** **Third Background Memorandum on Health Benefit Exchange Issues—Topic: Preparing for Potential 2012 Health Benefit Exchange legislation**

This is the third of three background memorandums that are designed to assist the Virginia Health Reform Initiative (VHRI) Advisory Council and Task Force members in providing options and recommendations on a Virginia Health Benefit Exchange to the Secretary of Health and Human Resources, Dr. Bill Hazel. Secretary Hazel along with the State Corporation Commission's Bureau of Insurance will work with the Virginia General Assembly, relevant experts, and stakeholders to provide recommendations regarding the governance and structure of the Virginia Health Benefit Exchange for consideration by the 2012 Session of the General Assembly. Final options and recommendations are due to the Governor and General Assembly members by October 1, 2011.

The Health Benefit Exchange (HBE) is the new marketplace for small group and individual insurance. The HBE was envisioned by the Patient Protection and Affordable Care Act (PPACA) and by various state laws (e.g., Massachusetts and Utah) that both preceded and informed PPACA's inclusion of a HBE. The intent of the HBE is to: improve small group and non-group insurance market performance through transparency, provide consumer education about various insurance choices, and provide assistance with eligibility determinations for Medicaid, premium assistance tax credits and cost-sharing reductions. The effect of the HBE, along with the market reforms and subsidies that go with it, should be to substantially increase the number of Virginians with private insurance coverage.

The focus of the first memorandum, dated April 15, 2011, was on governance issues. Establishing the basic structure and governance of Virginia's Health Benefit Exchanges is the first building block of the Exchange. The emphasis in the second memorandum was how to promote competition, that is, how to make insurance markets work better than they do now for small employers and for individuals buying on their own. The focus of the third memorandum is to provide a framework for moving forward with options for potential 2012 health benefit exchange legislation.

**Meeting and Public Comment Process on the Virginia Health Benefit Exchange**

There will be three meetings in 2011 with the VHRI Advisory Council on key HBE issues. The Task Force Members are welcome to attend as a member of the audience and provide comment on the discussions. These meetings will be one day meetings in Richmond, Virginia on:

- May 26, 2011,
- July 15, 2011, and
- September 9, 2011

Refer to the VHRI website (**http://www.hhr.virginia.gov/Initiatives/HealthReform/**) for the meeting materials and minutes of past meetings. Memorandums will be made available to the public simultaneously with being emailed to the Advisory Council and Task Force members so that it may be useful as an organizing device for public comments any citizen of the Commonwealth or interested party might like to make. We also encourage members of the Council and Task Forces to submit written comments so that the entire spectrum of ideas is collected prior to Advisory Council meetings. All written comments received by the designated time will be compiled and sent to members of the Council and Task Forces and the public prior to the next meeting of the VHRI Advisory Council, which is September 9, 2011. The memorandums and comments received will form the basis of the discussion at the public meeting.

Stakeholders and consumers can provide comments two ways:

- Written public comment will be accepted on a series of memorandums regarding HBE issues. We encourage those who submitted comments during the 2010 fall meetings or to the first two memorandums to resubmit their comments if they pertain to the HBE and the topics in this memorandum.
    - **The written comments on this August 12, 2011 memorandum are due by 5 p.m. on August 26, 2011.**
    - Written comments will only be received by submission to: VHRI@governor.virginia.gov with the subject line heading: Comments on September 9 Memorandum on Preparing for Potential 2012 Health Benefit Exchange legislation. **Comments sent any other way may not meet the deadline for submission.**

- Oral public comment will take place at the three Advisory Council meetings held in Richmond, Virginia.

**PREPARING FOR POTENTIAL**
**2012 HEALTH BENEFIT EXCHANGE LEGISLATION**

This memorandum has been organized into six parts:

I. The Charge (from the 2011Session of the General Assembly), including what the Secretary of Health and Human Resources must include in the report of recommendations to the Governor and the legislature by October 1, 2011,
II. What other states have done (or are doing) regarding legislation for the creation of Health Benefit Exchanges, and,
III. Preliminary Decisions/Discussion Points from the May 26, and July 15, 2011 meetings of the VHRI Advisory Council
IV. Clarification of the potential role of the Bureau of Insurance and the Exchange
V. Decisions that could be made by the Legislature, the Governance Structure, and the Director of the Health Benefit Exchange
VI. The Basic Health Plan

## I. The Charge

At the December 13, 2010 meeting of the Virginia Health Reform Initiative Advisory Council, there were two recommendations made regarding the planning for a Health Benefit Exchange. The first recommendation provided the intent to create a Virginia Exchange rather than default to the federal government:

> *Virginia should create and operate its own health benefits exchange to preserve and enhance competition. We suggest the Governor and legislature work together to create a process to work through the various issues in detail, with broad stakeholder input, in time for implementation to satisfy the timing requirements of the federal law.*

The second recommendation provided some basic principles to be part of any Exchange design:

> *Whatever form the Virginia Health Benefit Exchange (HBE) ultimately takes, there is broad agreement about what the HBE should achieve in practice, about what would be considered a successful HBE, and therefore what the Secretary, Legislature and Governor should keep in mind:*
>
> 1. *Provide employers with an opportunity to be successful financially while providing health insurance to their workers*
> 2. *Provide a marketplace that works well for those without insurance today*
> 3. *Provide a marketplace that facilitates the transformation of the delivery system to produce more value per dollar spent, by focusing on quality and transparency*
> 4. *Transparency in all things should promote choice, stability and innovation*
> 5. *The HBE must address the cost of health care and the competitive disadvantage that small firms and ultimately all United States firms labor under now. We should not miss an opportunity to explore how the HBE can help on the cost front.*
> 6. *The HBE should help educate employees and employers through a user-friendly website*
> 7. *Individuals and employees should be engaged in their own care as well as in regular wellness and prevention activities*
> 8. *A goal of the exchange should be to maximize choice, innovation, the number of competing qualified health plans and effective competition with transparency regarding cost and quality in driving consumer decision making.*
> 9. *Long term care insurance should be included in the exchange.*
> 10. *Above all: remember to keep it simple, so that employers and average citizens can understand how to use and benefit from the HBE marketplace.*

The VHRI Advisory Council's recommendations on the Exchange then served as a basis for House Bill 2434 (http://leg1.state.va.us/cgi-bin/legp504.exe?ses=111&typ=bil&val=hb2434) which states the intent of the General Assembly to create a plan for operating a health benefits exchange. This bill directs the Secretary of Health and Human Resources and the State Corporation Commission's Bureau of Insurance, to work with the General Assembly, relevant experts, and general stakeholders to provide recommendations by October 1, 2011, for consideration by the 2012 General Assembly regarding the structure and governance of the Health Benefit Exchange.

The plan for the Virginia Health Benefit Exchange must meet the federal requirements under the Patient Protection and Affordable Care Act. Based on the legislation, the recommendations should address at a minimum:

- Whether to create the HBE within an existing governmental agency, as a new governmental agency, or as a not-for-profit private entity;
- The make-up of the governing board for the HBE;
- An analysis of resource needs and sustainability of such resources for the HBE;
- A delineation of specific functions to be conducted by the HBE; and
- An analysis of the potential effects of the interactions between the Virginia HBE and relevant insurance markets or health programs, including Medicaid.

## II. What Other States Have Done Regarding Health Benefit Exchanges

As state legislatures continue to adjourn their regular sessions for the year, below is an update of what states have decided regarding health benefit exchanges as of August 5, 2011[1]:

- Health Exchange Planning Grants
  - 49 states (all but Alaska) applied for and received a health benefits exchange planning grant, but some states are ceasing activities including Florida, Louisiana, and New Hampshire.

- Early Innovator Grants for Health Benefit Exchange
  - 7 states – Kansas, Massachusetts, Maryland, New York, Wisconsin, Oklahoma, and Oregon – have received "early innovator" grants to develop HBE-oriented technologies and eligibility determination systems that can serve as models for other states. The University of Massachusetts Medical School, as the grantee, is leading a multi-state New England consortia for Connecticut, Maine, Massachusetts, Rhode Island and Vermont. Both Oklahoma and Kansas have returned their Early

[1] The key source for the legislative information is the McKenna Long and Aldridge LLP *State of the States* Report on Health Insurance Exchange Legislation, July 15, 2011.

Innovator grants.

- Legislation
  - Exchange Established by law:
    - Pre-PPACA (2): Massachusetts and Utah
    - Post-PPACA (10): California, Colorado, Connecticut, Hawaii, Maryland, Nevada, Oregon, Vermont, Washington, and West Virginia. As provided by the Kaiser Foundation, the chart below describes the structure and type of exchange for the 10 states that have Exchange legislation.

| State | Structure of Exchange | Type of Exchange |
|---|---|---|
| California | Quasi-governmental | Active Purchaser |
| Colorado | Quasi-governmental | Clearinghouse |
| Connecticut | Quasi-governmental | Active Purchaser |
| Hawaii | Non-profit | Clearinghouse |
| Maryland | Quasi-governmental | To be decided by the Board of Directors |
| Nevada | Quasi-governmental | Not addressed in legislation |
| Oregon | Quasi-governmental | Active Purchaser |
| Vermont | Operated by the state | Active Purchaser |
| Washington | Quasi-governmental | To be decided by the Board of Directors |
| West Virginia | Quasi-governmental | Not addressed in legislation |

    - Passed by legislature in both houses, vetoed by the Governor (1): New Mexico
    - In one of the houses within legislature (2): New Jersey and Pennsylvania
    - Implementation analysis/plan required (5): Illinois, Maine, North Dakota, Virginia, and Wyoming
    - Dead for 2011 because legislature has adjourned (27): Arkansas, Alaska, Arizona, Alabama, Delaware, Florida, Georgia, Iowa, Indiana, Idaho, Kansas, Kentucky, Louisiana, Minnesota, Missouri, Mississippi, Montana, North Carolina, Nebraska, New Hampshire, New York (expected to vote in September), Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, and Texas
    - No exchange legislation introduced (3): Michigan, Ohio, and Wisconsin

## III. Preliminary Decisions/Discussion Points from the May 26, and July 15, 2011 Meetings of the Advisory Council

**May 26, 2011 Meeting on Governance Structure**

Based upon the April 15, 2011 memorandum, stakeholder input and public comment, and the panel discussion and presentations at the May 26, 2011 meeting, the Advisory Council discussed the following seven governance questions:

1. Where should the governance structure of the Exchange be located?
2. Should there be a Governing Board and/or Advisory Committee?
3. Who should have the authority to appoint members to the Board/Advisory Committee?
4. What should be the size of the Board/Advisory Committee?
5. What should be the composition of the Board/Advisory Committee?
6. Who should hire the Executive Director for the Exchange?
7. Should the Governing Body of the Exchange be given administrative flexibility?

While recognizing additional information will be forthcoming at the July and September meetings that will further inform the Advisory Council's final recommendations, they made the following preliminary decisions on governance issues.

- The Governance Structure (either Governing Board/Advisory Committee or some mixture) will have flexibility in hiring, compensation, procurement, and will follow some version of FOIA exemptions within a format that is already in existence
- The Executive Director of the Virginia HBE will be hired by the board/committee
- The composition of the board/committee will have diverse representation
- Conflict of interest guidelines will be laid out, in specific format, and voted on later by the Advisory Council
- The appointment of membership to the board/committee will be by both the Governor and the General Assembly
- The size of the board/committee will be a membership of 11-15
- Terms on the board/committee will be staggered terms of 2 years not to exceed 4 consecutive years
- The board/committee should be chaired by the Secretary of Health and Human Resources

Also through a non-binding show of hands, the Advisory Council stated their initial preference on the location of the Governance Structure for the Exchange. Earlier in the discussions, they eliminated the option for creating a new state agency to oversee the exchange functions.

- 10 members preferred a Quasi Public Agency, similar to the Virginia Housing Development Authority
- 2 Members preferred an Existing State Agency, such as the State Corporation Commission
- 2 members preferred a Not for Profit Private Entity, similar to the Virginia Health Quality Center

**July 15, 2011 Meeting on Promoting Competition**

The focus of the May 26, 2011 meeting was on the various options Virginia should consider regarding the governance structure. The discussions at the July 15th meeting zeroed in on a multitude of policy decisions that must be made, affecting the competitive performance of insurance markets in Virginia, both inside and outside the HBE. While the first set of federal regulations has been released on the governance structure and some policy decisions, it appears

that the key choices will still be Virginia's responsibility after the regulation is final. Therefore, the key questions that were discussed at the July meeting and were the focus of public comment, are the following:

1. How should Virginia seek to build capacity within the Virginia HBE so that it can remain compliant with federal performance requirements while ensuring that over time Virginia maintains autonomy from the federal government?
2. Should the Virginia HBE be statewide, multi-state, or a set of geographically contiguous sub-state exchanges?
3. Should Virginia combine the non-group and small group risk pools or keep them separate as they are today?
4. How small is a "small group?"
5. Should Virginia require more benefits than the "essential benefits package" (EBP)?
6. Should Virginia make all market rules that will be adopted inside the HBE also applicable to the parallel markets (individual and small group) outside the HBE?
7. Should Virginia encourage or require the HBE to be more of an active purchaser or an open market facilitator?

The discussions at this meeting focused on the above questions and staff were asked to provide additional information and modeling of the various policy options at the September 9th meeting. In addition, there was considerable discussion of the role of Bureau of Insurance and the Health Benefits Exchange. The following section provided by the Bureau of Insurance provides clarification on what is required of the HBE in terms of certifying whether health insurers are proposing to offer, Qualified Health Plans within the HBE, and how the Bureau's capabilities and responsibilities already encompass or may be expanded to fulfill all or some of those functions. Note: some required functions of the HBE – for example, producing an objective ranking of all plans based on cost and quality criteria, operating a Navigator program and comparison web-sites to provide unbiased advice about plan choices to potential enrollees, and providing a cost-calculator so that enrollees can estimate their out-of-pocket liability with specific health plans prior to purchase -- would still be expected to be performed by the HBE independent of the BOI.

## IV. Clarification of the potential role of the Bureau of Insurance and the Health Benefits Exchange

At the July 15th meeting, there was considerable discussion on whether the Bureau of Insurance (BOI) should perform one of three roles (provided by the National Academy of Insurance) as it relates to the Exchange:

- Alternative 1: BOI would ensure that a plan seeking certification meets all licensure and solvency requirements, as well as all requirements under ACA for a qualified health plan.
- Alternative 2: BOI would determine whether a plan meets some aspects of ACA and/or other state requirements for a qualified health plan (as well as state licensure or solvency requirements) and the Exchange would determine whether a plan meets all other requirements for a qualified health plan.
- Alternative 3: BOI would do what they do now (ensure plans meet licensure and solvency requirements), but the Exchange would determine whether a plan meets all other ACA and Exchange requirements.

The Bureau of Insurance has provided the following information to clarify which Health Benefit Exchange requirements are generally within their current processes and procedures the BOI undertakes with its carriers and which are not. Ideally, the Bureau of Insurance and the Health Benefit Exchange will complement each other in all exchange functions. It is incumbent upon the Commonwealth to have a seamless system between the Exchange, BOI, and other state agencies, such as Medicaid.

**Requirements for Certification by the Health Benefit Exchange**

**NOTE**: The following requirements are applicable to the Exchange itself. However, the enforcement or verification of many of these requirements, while not specifically addressed in insurance laws or regulations in Virginia, are generally within the scope of processes and procedures that the BOI undertakes in its review of carriers. Enforcement and/or compliance verification by the BOI of one or more of these functions may be more efficient and eliminate redundancy, but legislation or regulation would likely be needed, and some mechanism for compensating the BOI for staff and resources to perform these functions for the Exchange may also be necessary.

| **Qualified Health Plan and Issuer Requirements** | **PPACA Citations** | **Proposed Federal Rule Citations** |
|---|---|---|
| Qualified Health Plan issuer must be licensed and in good standing | 1301 (a)(1)(C)(i) | 156.200 (b)(4) (note additional components) |
| Each QHP must provide the essential health benefits package in 1302(a). | 1301 (a)(1)(B) | |
| Issuer agrees to offer at least one QHP in silver and gold. | 1301 (a)(1)(C)(ii) | 156.200 (c)(1) |
| Issuer agrees to charge the same premium rate for each QHP w/o regard to whether plan is offered inside or outside the Exchange. | 1301 (a)(1)(C)(iii) | |
| Issuer must provide applications and notices | | 156.250 150.230(b) |
| Rating variations for issuers | | 156.255 |
| Enrollment Periods | | 156.260 |
| Enrollment Process | | 156.265 |

| Qualified Health Plan and Issuer Requirements | PPACA Citations | Proposed Federal Rule Citations |
|---|---|---|
| Termination General Requirements | | 156.270 |
| Segregation of Funds for Abortion Services | | 156.280 |
| SHOP Standards | | 156.285 |
| Recertification/Decertification | | 156.290<br>155.1075<br>155.1080 |
| Rx Drug Distribution Cost Reporting | | 156.295 |
| Stand-alone Dental Plans | | 155.1065 |

## Certification of Qualified Plans

The Patient Protection and Affordable Care Act requires an Exchange to make qualified health plans available to qualified individuals and qualified employers and to certify, recertify, and decertify qualified health plans. In order to be certified, a qualified health plan must satisfy the requirements shown below. The requirements for which the Bureau of Insurance (BOI), has, does not have, or may have in the future, regulatory oversight are also identified below.

| To Be Certified Plans Must: | PPACA Citations | Proposed Federal Rule Citations | BOI Review, Approval, Enforcement Authority |
|---|---|---|---|
| Meet marketing requirements – no practices or plan designs that discourage enrollment | 1311(c)(1)(A) | 156.225 | BOI currently enforces statutes and regulations addressing marketing of health insurance, but additional regulation may be needed to address all requirements addressed in the federal law or regulations |
| Provide adequate networks – ensure sufficient choice of providers and information on provider availability | 1311(c)(1)(B) | 156.230<br>155.1050 | ♣ BOI does not oversee or enforce, *(see footnote)* |
| Establish or evaluate the service areas of QHPs to determine if a minimum geographical area is covered; area established w/o regard to racial factors, etc. | 1311(c)(1)(B) | 155.1055 | ♣ BOI does not oversee or enforce *(see footnote)* |
| Include in networks essential community providers that serve low-income, underserved communities | 1311(c)(1)(C) | 156.230<br>156.235 | ♣ BOI does not oversee or enforce *(see footnote)* |

♣ ***While BOI does not oversee or enforce the requirements for certification in this area, some or all of the requirements may be addressed in laws or regulations within the purview of the Virginia Department of Health***

| To Be Certified Plans Must: | PPACA Citations | Proposed Federal Rule Citations | BOI Review, Approval, Enforcement Authority |
|---|---|---|---|
| *Implement quality improvement strategies through market-based incentives* | 1311(c)(1)(E) | See 1311(g)(1) for details | ♣ BOI does not oversee or enforce *(see footnote)* |
| *Utilize a single streamlined application to determine eligibility for enrollment.* | 1311(c)(1)(F) | 155.405 | BOI currently reviews and approves application forms. A uniform form has been developed, and BOI will likely approve its use, but legislation or regulation may be necessary to effect this approval. |
| *Utilize the standard format established for presenting health benefits plan options* | 1311(c)(1)(G) | 155.205(b)(1) | BOI does not currently require or approve forms for presenting health benefit options, but a standard form has been developed, and BOI will likely approve is use. However, legislation or regulation may be necessary to effect this approval. |
| *Provide information to the Exchange and enrollees on quality measures for health plan performance* | 1311(c)(1)(H) | See 1311 (h)(1) regarding quality improvement provisions | ♣ BOI does not oversee or enforce *(see footnote)* |
| **Transparency in Coverage** | | | |
| *Submit justifications of any premium increase prior to implementation and post it on the QHP's website. Submit benefit rate info annually.* | 1311(e)(2) | 156.210 155.1020 | Anticipated to be a BOI oversight function, but additional legislation or regulation may be necessary to effect and administer this requirement. |
| *Use plain language* | 1311(e)(3)(B) | 156.220(c) | Anticipated to be a BOI oversight function, but additional legislation or regulation may be necessary to effect and administer this requirement. |
| *Requires Issuers to allow individuals to learn the cost-sharing under their plan for furnishing a specific item or service by a participating provider upon request through a website* | 1311(e)(3)(C) | 156.220 (d) | Not a BOI function, however BOI could review these measures through market conduct examinations and through the investigation of consumer complaints |

♣ ***While BOI does not oversee or enforce the requirements for certification in this area, some or all of the requirements may be addressed in laws or regulations within the purview of the Virginia Department of Health***

## V. Decisions that could be made by the Legislature, the Governance Structure, and the Director of the Health Benefit Exchange

Following the July 15th discussion, we determined that the Advisory Council should vote at the September meeting on which of the multitude of Exchange questions/issues should be addressed by the legislature, which should be defined by the Governing Board for the Exchange, and which should be defined by the Executive Director of the Exchange. For those governance structure and/or policy decisions that are determined should be part of the potential 2012 legislation, we will seek the Advisory Council's guidance on those issues.

As we discuss the need for potential 2012 legislation, it is important to be aware of where Virginia needs to be in order to apply for a Level Two Establishment grant to receive federal funding to create and initially operate a health benefit exchange. The last opportunity to apply for this funding is June 29, 2012. In order to receive funding, Virginia must demonstrate completion (Tasks 1-7) or progress (Tasks 8-11) in the 11 exchange establishment core areas listed below. This level two funding and the requirements are likely an early proxy for demonstrating readiness for a Virginia Benefit Exchange in 2013, in order to avoid federal operation of the HBE.

1. Background Research completed on the individual, employer, and insurance markets
2. Stakeholder Involvement
3. The state has the necessary legal authority to establish and operate an Exchange that complies with federal requirements and provides for governance and exchange structure
4. Governance structure determined and established
5. Coordination has been established with the State Medicaid Agency and the state Department of Insurance, and other programs as appropriate
6. Established business requirements for Exchange IT systems
7. Plan for ensuring sufficient funding for ongoing operations after January 1, 2015
8. Progress on Oversight and Program Integrity related to federal and state funds utilized to start-up and operate an Exchange
9. Show progress implementing health insurance market reforms
10. Progress on developing mechanisms to provide assistance to individuals +and small businesses, coverage appeals and complaints
11. Progress on the development and implementation of Business Operations/Exchange Functions

We would like to receive public comment on where we should draw the lines for the responsibilities, as well as additional duties that may fall into one of these three buckets: legislation, governing board, and Executive Director.

**Major Decisions That Must Be Addressed by the General Assembly**
**NOTE: All but 1, 2, and 3b can be delegated to a Governing Board if the General Assembly So Chooses**

1. To create a Health Benefit Exchange, so that Virginia policy makers will have maximum freedom to shape health insurance markets and health reform in Virginia (HB 2434)
2. Governance (required by HB 2434):
    a. Where to house it
        i. Existing state agency
        ii. New public entity
        iii. Non-profit
    b. Whether Board is Governing or Advisory; whether to have both
    c. Composition of the Board and the selection process, terms, and conflict of interest rules
    d. Reporting requirements of Board/HBE to Legislature, Committees of jurisdiction
    e. Level of administrative flexibility hiring, compensation, procurement, and transparency
3. Major Policy Directions to be set by Legislature, (all but 3.b may be deferred to Board)
    a. To create
        i. Single administrative structure or separate
        ii. Within HBE, SHOP vs. non-group pool set separate
    b. To set parameters of Board's Discretion
        i. To select executive director and staff
        ii. To have discretion to require more than the federal requirements for health plan participation
            1. No
            2. Yes
                a. If yes, what may the Board consider
                    i. Quality of health plans
                    ii. Quality of care by providers in plan networks
                    iii. Premium bids relative to others or to an objective benchmark
                    iv. Other factors the Board believes could affect value to consumers and purchasers
                b. If yes, the amount of discretion within the what(s)
        iii. To be an "Active Recruiter" of plans to compete inside the HBE
            1. If yes, define Active Recruiter functions and discretion the Board would have to pursue plans.
    c. To require risk pools of SHOP and non-group markets to be kept separate
        i. In 2014
        ii. Schedule for revisiting this question by legislature
        iii. Note: if they are melded inside the HBE, they should be melded outside the HBE as well, to prevent adverse selection risk and preserve competition between the markets
    d. To define "small" as 1-50 until 2016 (2016, must go up to 100), starting in 2017, could be larger if legislature/HBE decides to
        i. Note: Virginia law now is 2-50. Defining small to include a firm size of 1 permits the self-employed to purchase in the group market. This is permitted

under PPACA, but is not required. It would be advisable to conform the small group definition inside and outside the exchange, to prevent obvious selection risk if self-employed may enter the SHOP exchange (and be pooled with other small groups) but must buy in non-group market outside the HBE.

ii. Set schedule for revisiting definition of small each year after 2015

iii. OR let Board decide each year after 2015

e. To give Board authority to determine a funding mechanism in order to self-finance the HBE after 2014

i. Financial reporting requirements separate from operational reporting requirements

ii. Coordination with and auditing by state fiduciaries required

f. To decide congruence (e.g., FOIA) or exemptions (procurement, personnel) from current state laws

g. To define interactions with other state (and federal) agencies

i. Responsibility for enrollment and eligibility determination

1. Interface with BOI
2. Interface with OSHHR, DMAS, and other state agencies
    a. Information system/portal construction
3. Interface with HHS, IRS, DOL, etc.

h. To set broad goals and accountability mechanisms

i. Goals (to consider):

1. expand coverage in small group and non-group markets
2. enroll at least 3% of Virginians by 2016
3. lower premium growth trend off baseline by 10% by 2020, or enough to attract businesses to Virginia

ii. Reporting requirements

1. Define Oversight committees

i. To define congruence of competition policy inside and outside HBE

i. Roles of agents inside and outside the HBE

1. Agents can be Navigators, come 2014
2. Certification requirements for Navigators
3. Payment rules for Agents, post-2014, inside and outside the HBE

ii. Non-group market

1. Benefit mandates, post-2014, congruent with Essential Benefits Package, inside and outside exchange, or not
2. Allowed product offerings, post 2014, inside and outside Exchange
3. Transparency/reporting requirements, post-2014, inside and outside Exchange
4. Amend oversight and regulatory authority for BOI for inside and outside the exchange market, if necessary

iii. Small group market

1. Benefit mandates, post-2014, congruent with Essential Benefits Package, inside and outside exchange, or not
2. Allowed or required product offerings, post 2014, inside and outside Exchange
3. Transparency/reporting requirements, post-2014, inside and outside Exchange
4. Amend oversight and regulatory authority for BOI for inside and outside the exchange market, if necessary

4. Delineate the Duties of the Exchange (the following list are the minimum to meet compliance with ACA)
    a. Certification, recertification, and decertification of qualified health plans
    b. Call Center
    c. Exchange Website

d. Premium Tax credit and cost sharing reduction calculator
e. Quality rating system
f. Navigator program
g. Eligibility determinations for exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid
h. Seamless eligibility and enrollment process with Medicaid and other state health subsidy programs
i. Enrollment process
j. Applications and notices
k. Individual responsibility determinations
l. Administration of premium tax credits and cost-sharing reductions
m. Adjudication of appeals of eligibility determinations
n. Notification and appeals of employer liability
o. Information and reports to IRS and enrollees
p. Outreach and Education
q. Free Choice Vouchers
r. Risk adjustment and transitional reinsurance
s. SHOP exchange-specific functions

**Major Policy Decisions That Could Be Delegated Entirely to the Board**

1. Determine Board's meeting schedule
2. Hire Executive Director (ED), determine compensation, and whether it serves at the pleasure of the Board
    i. Delineate authority of ED and what requires Board's Approval
3. Rent space using Commonwealth of Virginia General Services entity
4. Set fees for financial self-sustainability, pursuant to authority granted by legislature
5. All functions required to be compliant with PPACA, not elsewhere specified
    i. One-stop Enrollment and eligibility determination system, including eligibility for Medicaid/FAMIS, premium tax credits, cost-sharing tax-credits, and lower wage-small employer tax credits
    ii. Determine if individual is entitled to an exemption from the purchase mandate due to affordability or religious reasons
    iii. Premium aggregation service for small employers (so they may write one check per month)
    iv. Website with comparative plan information, ombudsman, toll free hotline, Navigator program, cost calculator, value ranking, etc.
    v. Review premium growth inside and outside the HBE, and use that knowledge to make judgments about how small is small and whether market performance in either or both sectors could be improved with new or relaxed rules
    vi. Determine which plans are qualified health plans and that may sell inside the HBE (and in which market), specify certification, de-cert, and re-cert processes
        1. If exclusion is to be based on premium bids, determine exclusion rule a priori and publicly announce prior to deadline for filing bids
        2. BOI (or HHS) rate review may inform this decision
    vii. Communicate relevant information with the IRS and HHS
6. Choose which mechanism and how to implement risk corridors, reinsurance, and risk adjustment, inside and outside the HBE and therefore in conjunction with the BOI
7. Discretion to temporarily adjust market rules inside or outside the HBE, if, in the combined judgment of the HBE Board and the Commissioner of the BOI, extreme adverse selection threatens the financial integrity and competitive potential of the HBE *OR* of the outside market. These adjustments could be over-ridden by the legislature when next in session, after relevant reports and testimony by the BOI, the Executive Director of the HBE, and relevant stakeholders.

| |
|---|
| These adjustments could include:<br>i. Temporary freeze in enrollment in certain products<br>ii. Temporary adjustments to the risk adjustment algorithm |
| **Major Policy Decisions That Could Be Delegated to the Executive Director** |
| 1. Under the direction of the Board, the Executive Director shall be:<br>a. The Chief Administrative Officer of the Exchange;<br>b. Direct, administer, and manage the operations of the Exchange;<br>c. Perform all duties necessary to comply with the Exchange legislation, other state law and regulations, and the Affordable Care Act |
| 2. Hire staff<br>i. Need to determine whether hiring practices are within state personnel rules or whether there is flexibility |
| 3. May retain independent contractors as necessary to carry out the planning, development, and operations of the exchange<br>i. Need to determine procurement rules |
| 4. Enter into interagency agreements or memorandum of understanding with the Department of Medical Assistance Services, the Bureau of Insurance, and other appropriate state agencies to coordinate, subcontract, share data, or delineate the roles of the agencies with the Exchange |

## VI. The Basic Health Plan

One of the original questions that has yet to be discussed substantively within the VHRI is whether or not Virginia should incorporate a Virginia-specific version of the "basic health plan" option as a type of "bridge" insurance product for families with incomes that hover but fluctuate near the income dividing line between being eligible for Medicaid and eligible for premium and cost-sharing subsidies inside the HBE. We welcome public comment on this issue.

Through the Affordable Care Act (ACA), states are granted the option to create and implement a Basic Health Program (BHP) to adults with incomes between 133 and 200% of the federal poverty level (FPL) and legally residing immigrants with incomes below 133% FPL whose immigration status disqualifies them from Medicaid. An additional component of the BHP is that the federal government will give a state 95% of what they would have otherwise issued in tax credits and cost-sharing subsidies for out-of-pocket costs had these individuals enrolled in a regular Health Benefit Exchange (HBE) plan. Within the BHP model, the federal dollars would be placed in a state trust fund and may be used only "to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in" BHP" (ACA §1331 (d)(2).

If a state chooses to create and operate a BHP, the U.S. Department of Health and Human Services (HHS) will make one BHP payment to the state before the federal fiscal year begins (based on the best available projections). If at the end of the fiscal year the amount turns out to be too high or too low, HHS will make an offsetting correction to the following year's payment. In designing a BHP, a state is required to use a competitive

process to contract with health plans or provider groups that meet the following requirements:

- All minimum essential benefits (yet to be issued by HHS) under ACA are covered.
- The BHP consumer is not charged premiums that exceed what the consumer would pay in the exchange.
- The consumer receives coverage with an actuarial value that meets or exceeds certain minimum thresholds,
- The plan is either a "managed care system…" or a "system…that offer[s] as many of the attributes of managed care that are feasible in the local health market." (ACA §1331 (c)(2)(C))
- The state negotiates to have the plan or provider implement innovations that include, "care coordination and care management," "incentives for use of preventive services," and efforts to "maximize patient involvement in health care decision making" combined with "incentives for appropriate utilization." (ACA §1331 (b)(2)(A))
- "To the maximum extent feasible," the consumer is offered a choice of plan options. (ACA §1331 (c)(3)(A))
- If operated by an insurer,
    - The plan must report on state-selected performance measures that focus on quality of care and improved health outcomes; and
    - The plan's medical loss ratio (proportion of premium payments that go towards health care and quality improvement rather than to administration) may not fall below 85%.

The Basic Health Plan (BHP) option brings an array of advantages and disadvantages to states. Given Virginia's successful track record, and current planned expansion of Medicaid managed care and the clinical value and cost efficiency of continuous relationships with "usual source of care" providers, if the parameters of the BHP option can be structured appropriately, it could have merits for the Commonwealth as a whole, specifically patients, and participating health plans. Conversely, and of equal importance, is the understanding that the creation of a BHP is essentially the expansion of another public health coverage option. Additionally, developing a new program requires administrative resources, resources that are scarce as a result of multi-year budget problems. States are finding it difficult to implement the minimum provisions of the ACA without designing and implementing a new, state-run insurance program.

While in planning conversations regarding a possible Virginia exchange, it is necessary to consider the impacts that a BHP is likely to have on the HBE and on families. If an individual is participating in a BHP, they are prohibited from entering the HBE. Offering a BHP then could reduce the size of the risk pool in the HBE and thereby render it more unstable or at least more vulnerable to a variety of adverse selection risks, especially in

the early years. On the other hand, when considering the size of the population that may be eligible for Medicaid part of the year and eligible for HBE premium and cost-sharing subsidies in other parts of the same year (as much as 50% of adults below 200% of poverty according to a recent credible estimate) having an insurance product and a stable set of providers for which they would be continuously eligible could be beneficial for the continuity of high quality care, with stable costs and coverage for families and governments alike. The eligibility "churning" problem is serious, and could be addressed in other ways, like presumptive 12-month eligibility for Medicaid, but that has state cost implications that must be balanced against other priorities. This is not a simple issue, which is why we welcome public comments to inform VHRI deliberations.

**Please let us know if you have any questions concerning this memorandum. We particularly would like to receive public comment on Sections V and VI. Due to the number of remaining topics to be addressed, we are expanding the time frame for the September 9, 2011 from 9:00 a.m. to 5 p.m.**

The meeting will be held :

Virginia Department of Health Professions (located at the Perimeter Center)
2nd floor Board room in the Commonwealth Conference Center
9960 Mayland Drive, Henrico, Virginia 23233

Thank you for your service to the Commonwealth of Virginia.